Pressure Reduction/Comfort Chair Assessment Form

| Name: |  | | | | Sex: 🞏 M 🞏 F | | 🞏 Other: |  | | DOB: |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Address: | |  | | | | | Phone No: | |  | | |
| Clinician: | | |  | | | Agency: |  | | | | |
| People consulted: | | | |  | | | | | | | |

**MEDICAL HISTORY**

| Diagnosis/Prognosis: | | | | |  | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | | | |
| Pain: |  | | | | | | | | | |
| Height: | |  | | | | | Weight: |  | |  |
| Sensation: (note areas that are abnormal or insensate) | | | | | | | | |  | |
|  | | | | | | | | | | |
| Skin History/Integrity: Intact Hx of Pressure Areas Red Areas Open Areas Scar Tissue | | | | | | | | | | |
| *(Refer to Braden Scale)* | | | | | |  | | | | |
| Pressure Relief: Independent Assisted Dependent | | | | | | | | | | |
| Methods Used: | | | |  | | | | | | |
| Cushions: | | |  | | | | | | | |
| Bladder Management: Continent Incontinent | | | | | | | | | |  |
| Bowel Management: Continent Incontinent | | | | | | | | | |  |

**SOCIAL HISTORY**

Environment (note space for chair, other furniture, floor surface etc.)

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| Activity Configuration (note time spent in chair, activities to be done in chair etc) |
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**TRANSFERS/MOBILITY**

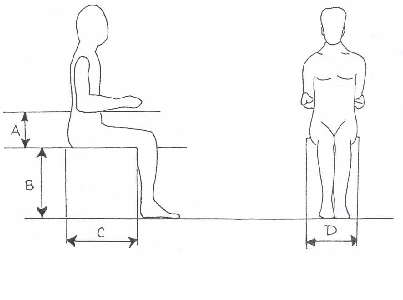
Transfer on and off chair:

Weight shifting in chair:

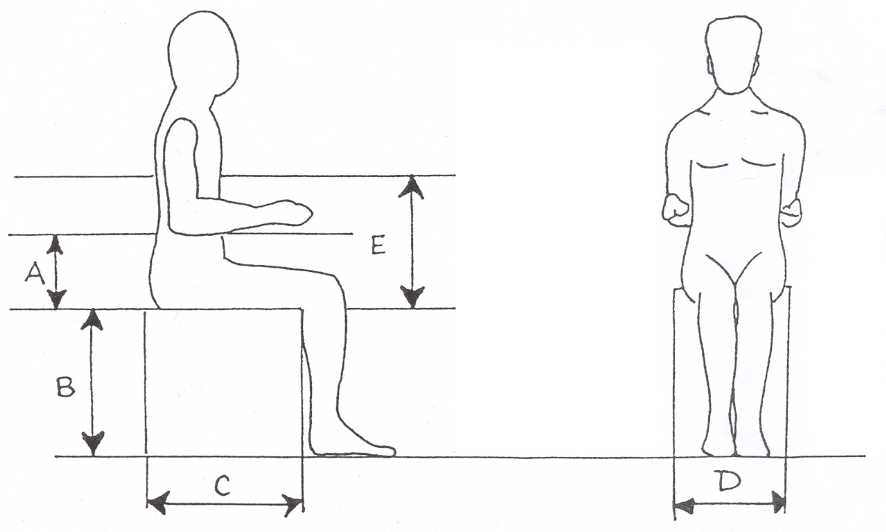
Does the client have significant contractures or extensor spasm:

Carer needs in assisting client:

**BASIC DIMENSIONS:**



| A | Seat - elbow: | | |  |
| --- | --- | --- | --- | --- |
| B | Back of knee - heel: | | |  |
| C | Posterior of buttocks - back of knee: | | |  |
| D | Widest point at hips or thighs: | | |  |
| Height: | |  | Weight: |  |



**OPTIONS FOR CHAIR**

Customisation needed: Yes No Details:

Fabric preference: (vinyl, dartex, synergy, cloth, colour etc.)

Incontinence covers required: Yes No Seat belt required: Yes No

Armrest covers: Yes No Is the chair required for transport in Access Cab or a van: Yes No

**CARER/CLIENT GOALS and CONCERNS**

| Period of Use: |
| --- |
|  |

**ADDITIONAL NOTES/SUMMARY**

| Period of Use: | | | | | |
| --- | --- | --- | --- | --- | --- |
|  | | | | | |
|  | | | | | |
|  | | | | | |
| Short term plan(s): | Trial Equipment: | | |  | |
|  | Date/Place: | |  | | |
|  | Obtain further information: | | | |  |
|  | Other: |  | | | |

| Info given to client: | 🞏 Prescription agreement form: |  |
| --- | --- | --- |
|  | 🞏 “Preventing Pressure Sores” pamphlet |  |

| **Clinician’s Name:** |  |  |  |
| --- | --- | --- | --- |
| **Clinician’s Signature:** |  | **Date:** |  |